GRIEVANCE RESOLUTION LETTER

[Date]

[Member's Name]
[Address]
[City, State, Zip]

HWLA Member Identification #: ***[insert number]***
DMH IS #: ***[insert number]***

Dear [Member]:

A decision has been made about your grievance of <insert date>, about <state reason> on <date of incident>.

DMH Patients' Rights has worked with <name of facility and/or title of person> to investigate your grievance.

<state findings>

<state conclusion and result, i.e. this is what will happen>

We value you as a DMH HWLA member. We hope you agree with the decision.

Your concerns help us to monitor the services provided and to improve care for all of our members.

If you have questions or concerns, please contact [insert name], DMH Patients' Rights at (213) 738-4949.

NOTE: If you cannot read or understand this letter, call DMH Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

_____
(Name of Patents' Rights Advocate)

c: Requesting Provider/Clinic/CAU